STATE OF MICHIGAN

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner

v **File No. 121844-001**

Blue Cross Blue Shield of Michigan
Respondent

_____

Issued and entered
this _____ day of November 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On June 13, 2011, XXXXX, on behalf of her minor son XXXXX (Petitioner), filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act (PRIRA), MCL 550.1901 *et seq.* The Commissioner accepted the request on June 20, 2011.

The Petitioner receives health care benefits as an eligible dependent under his father's health benefit plan issued by Blue Cross Blue Shield of Michigan (BCBSM). The Petitioner's family lives in XXXXX but their health care coverage is provided through a Michigan business that employs the Petitioner's father. The benefit contract is issued in Michigan and is therefore subject to the regulatory authority of the Michigan Office of Financial and Insurance Regulation.

This review involves medical issues. As required by Section 11(6) of the PRIRA, the medical issues were analyzed by an independent medical review organization which submitted its report and recommendation to the Commissioner on July 5, 2011. (A copy of the complete report is being provided to the parties with this Order.)

II. FACTUAL BACKGROUND

The Petitioner was born in March 2005. He has been diagnosed with autism and has received various forms of therapy since his second birthday. At issue in this appeal is coverage

for 10 therapy sessions provided by an occupational therapist between January 27, 2010 and April 14, 2010. The therapy was conducted at the XXXXX XXXXX and XXXXX Center of the XXXXX XXXXX and XXXXX XXXXXX Hospital in XXXXXX. The amount in dispute is $3,834.00.

BCBSM denied coverage for the 10 therapy sessions. The Petitioner appealed the denial of coverage through BCBSM's internal grievance process. BCBSM issued an adverse determination dated March 22, 2011. [1]

III. ISSUE

Did BCBSM properly deny coverage for the Petitioner's therapy sessions?

IV. ANALYSIS

BCBSM's Argument

BCBSM states in its adverse determination of March 22, 2011:

> As indicated in your Community Blue Group Benefits Certificate in Section 4, physical therapy, occupational therapy, and speech therapy are covered. The care received was submitted as physical therapy, which an occupational therapist is not covered to perform physical therapy services. While I understand that the procedure codes are interchangeable for physical as well as occupational therapy, the services were reported as physical therapy, not occupational therapy. Therefore, I cannot approve payment as occupational therapists are not covered to perform physical therapy.

Petitioner's Argument

In a letter to BCBSM dated May 31, 2011, the Petitioner's mother explained why they are challenging BCBSM's denial of coverage:

> [BCBSM has] stated that the occupational therapy was reported as physical therapy and that it's not covered when performed by an occupational therapist. We have sent BCBSM the occupational therapist's notes from every session clearly showing that no physical therapy was performed. In addition, the

1 This adverse determination was issued by BCBSM, erroneously, as a federal employee appeal. As a result, BCBSM provided the Petitioner's family with incorrect information about their appeal rights. The Commissioner finds that the present appeal is timely based on the date BCBSM issued the correct appeal information. BCBSM has not asserted that the Petitioner's appeal is untimely.

> provider's billing manager has confirmed that no billing codes used in their filing of the claims state strictly physical therapy (there were procedure codes reported that are used interchangeably for PT and OT).

Commissioner's Review

While this appeal has a somewhat complicated procedural history, the appeal itself is not complex. BCBSM asserts a single reason for denying coverage: no benefits are provided when physical therapy is performed by an occupational therapist. The Petitioner's parents assert that no physical therapy was performed. BCBSM agrees with the Petitioner that the actual procedure codes for OT and PT can be used interchangeably.

In order to determine the nature of the therapy provided on the dates in question, the Commissioner requested analysis by an independent medical review organization. The IRO reviewer in this case is a physician in active practice who is certified by the American Board of Pediatrics with a subspecialty in developmental-behavioral pediatrics. The reviewer is an assistant professor of pediatrics at a Midwestern university school of medicine and is a member of the American Academy of Pediatrics, the International Society on Infant Studies, the Society of Developmental and Behavioral Pediatrics, and the Society for Research in Child Development. The IRO reviewer examined the medical records and other documents submitted by the Petitioner's parents and by BCBSM. The reviewer's report includes the following conclusions:

> This case is a billing issue not a question about clinical use of services. The enrollee requested and was authorized to receive occupational therapy for his autistic disorder. He received the requested and authorized therapies. This occupation[al] therapy was provided as part of a parent-training program for autistic children. Payment was denied because the health plan states that the enrollee received physical therapy rendered by an occupational therapist. In addition, the health plan states that because an occupational therapist provided him physical therapy, they cannot pay for his therapy. Based on the documentation provided, the child and family did not request, were not authorized, and did not receive physical therapy. Based on the documentation here, the child and family requested occupational therapy, were authorized to receive occupational therapy, and received occupational therapy. Denial of this payment should be overturned.

The Commissioner is not required in all instances to accept the IRO's recommendation. However, the IRO's recommendation is afforded deference by the Commissioner. In a decision to uphold or reverse an adverse determination, the Commissioner must cite "the principal reason or reasons why the Commissioner did not follow the assigned independent review organization's

recommendation." MCL 550.1911(16) (b). The IRO reviewer's analysis is based on extensive expertise and professional judgment and the Commissioner can discern no reason why the recommendation should be rejected in the present case.

The Commissioner finds that the Petitioner received occupational therapy on the dates in question. BCBSM's denial of coverage is not consistent with the terms of the certificate.

V. ORDER

Respondent Blue Cross Blue Shield of Michigan's final adverse determination of March 22, 2011, is reversed. BCBSM is required to cover the Petitioner's occupational therapy sessions provided between January 27 and April 14, 2010. Coverage shall be provided within 60 days of the date of this Order and BCBSM shall submit to the Commissioner proof of that coverage within seven (7) days after the coverage is provided.

To enforce this Order, the Petitioner must report any complaint regarding the implementation of this Order to the office of Financial and Insurance Regulation, Health Plans Division, toll free 877-999-6442.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

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R. Kevin Clinton
Commissioner